

**PHYSICIAN CERTIFICATION
for Family or Medical Leave**

Name _____ Title _____
Department _____ Employee Payroll No. _____
Status Full Time Part Time Temporary Date _____

To be Completed by Human Resources

The above named Employee is requesting family and medical leave from work with his/her employer _____
Name of Employer

It is our understanding that you are currently treating _____

The Patient is: the Employee Spouse of the Employee Parent of the Employee Child of the Employee

The Employee is requesting full day leave from ___/___/___ until ___/___/___

The Employee is requesting leave on an intermittent or reduced scheduled for the following dates: _____

Job description (if applicable) is attached.

To be Completed by Physician

Please assist us by clarifying the facts about the patient being treated.

As a duly authorized medical care provider, I verify that I am currently treating _____
Name of Patient

2. The Patient has been diagnosed and is receiving treatment for the following condition: _____

3. The condition began on ___/___/___

4. As a result of that condition, it is my opinion that:

The Employee is currently unable to perform his/her employment functions set forth on the attached job description.

The Employee is currently needed to care for the Patient.

Intermittent leave is medically necessary for the Employee, or to care for the Patient.

None of the above.

5. In my opinion, the Employee will not be able to return to work until (provide date if possible)

Physician's signature _____

Date _____

Phone No. _____

Physician's printed name _____

Office mailing address _____

Return Completed Form To: Human Resources Dep't